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## Death of a Remedy: The Supreme Court's Ill-fated Decision to Foreclose an Avenue of Liability against Managed Care Organizations under ERISA in *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143 (2000)

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# Death of a Remedy: The Supreme Court's Ill-fated Decision to Foreclose an Avenue of Liability Against Managed Care Organizations Under ERISA in *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143 (2000)

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\* Sara L. Broyhill, University of Nebraska-Lincoln, B.A. 1998; J.D. 2001. NEBRASKA LAW REVIEW, Executive Editor 2001. Special thanks to Professor Craig Lawson for the invaluable insight he provided in refining this note.

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# I. INTRODUCTION

The United States health care system is under attack. Patients are fed up with the low quality of care they receive from their health care providers due to managed care's cost-cutting consequences. Today, health care costs are so high that most people can only afford to receive medical care through an employee benefit plan. While costs have escalated, however, the quality and variety of medical services covered has declined. Society is enraged that the medical system allows health care providers to limit the types of medical services covered in a health care plan while it tolerates a lower standard of quality for the services actually provided.

This trend toward a decrease in the quality of health care began when the nation's health care system moved from the traditional "fee-for-service" care to "managed care."<sup>1</sup> In 1973, Congress passed the Health Maintenance Organization Act (the "HMOA"), which promoted managed care organizations ("MCOs").<sup>2</sup> Congress initially intended the HMOA to "maintain" the country's good health in a preventative manner, rather than to treat the country's failing health. Eventually, employers recognized managed care as an effective system to reduce the escalating costs of health care because of the limited services it provided.

Only months after Congress passed the HMOA, Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA"), designed to "promote interests of employees and their beneficiaries in employee benefit plans."<sup>3</sup> Thus, at the time Congress enacted ERISA, the system of "managed care" was new and relatively rare.<sup>4</sup> No one

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1. See discussion *infra* notes 6-15 and accompanying text.  
 2. Pub. L. No. 93-222, 87 Stat. 914 (1973)(codified at 42 U.S.C. §§ 300e et seq. (1994)).  
 3. Pub. L. No. 93-406, 88 Stat. 829 (codified at 29 U.S.C. §§ 1001 et seq. (1994)).  
 4. See *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983).

anticipated the long-term ramifications that resulted when the two acts inevitably became entangled.<sup>5</sup>

These ramifications, however, eventually became evident. In the late 1980s and early 1990s, large numbers of providers switched to managed care to contain costs.<sup>6</sup> Managed care successfully reduced costs because it primarily seeks to reduce utilization of health care services.<sup>7</sup> Tension soon developed, however, between managed care's goal to reduce utilization with ERISA's goal to protect beneficiaries.<sup>8</sup> Quality soon gave way to physicians' financial self-interest as MCOs developed procedures to induce physicians to substantially reduce and even deny patient care.<sup>9</sup> To limit utilization, primary care physicians served as gatekeepers to limit specialist services, outpatient procedures reduced hospitalization, prospective utilization reviews screened covered services, and coverage was denied for any experimental treatments.<sup>10</sup> Most significantly, MCOs implemented capitation requirements, offering physicians a fixed amount per patient regardless of how much or how little care the patient needed, encouraging physicians to limit the amount of care they delivered.<sup>11</sup> Unfortunately, some patients were denied necessary care and sustained serious injury; some even died.

While the American health care system transformed rapidly, patients struggled to redress their grievances against the MCOs. Ten-

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5. See MK Gaedeke Roland, Comment, *Looking for a Prince Among the Frogs: Solutions to ERISA's Preemptive Effect on Improving Health Care*, 47 BUFF. L. REV. 1487, 1488 (1999)(explaining that HMOs were largely unheard of in employee benefit packages around the time the two acts were passed and that no one could have foreseen how their juxtaposition would implicate the health care industry).

6. See Robert W. McGarrah, Jr., *Managed Care and the Evolving Link Between Patients' Rights and Employees' Rights*, SF28 A.L.I.-A.B.A. 65, 68 (2000).

7. See RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 568 (1997) ("[Managed care plans] use prospective utilization review techniques as well as practice guidelines to control physician utilization of resources").

8. See Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 364 (1994)(describing the tension physicians faced between reducing health care cost by limiting the amount of treatment rendered and satisfying the patient's desire to receive all available medical treatment).

9. See Roland, *supra* note 5, at 1496-98 (stating that "[s]hortly following the enactments of ERISA and HMOA, cost containment became the major goal of the nation's health policy"); Julie K. Locke, Note, *The ERISA Amendment: A Prescription to Sue MCOs for Wrongful Treatment Decisions*, 83 MINN. L. REV. 1027, 1050-51 (1999)(stating that "[a]s more employers realized the cost benefits of managed care, membership in MCOs exploded, but physicians and MCOs began to abuse the cost containment features of managed care health plans to the detriment of employee beneficiaries").

10. See Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1223-25 (1997).

11. See *id.* at 1226.

sions mounted between the traditionally high medical malpractice standard and the cost control methods of managed care. A vast majority of MCOs qualify as employee benefit plans under ERISA, and ERISA preempts all state law claims that "relate to" an employee benefit plan.<sup>12</sup> A broad reading of ERISA's preemption clause would, therefore, grant managed care entities protection from most state law tort claims. Once in federal court under ERISA, however, many patients find that ERISA does not grant them a viable alternative remedy against their MCO.<sup>13</sup> To make matters worse, many courts have interpreted ERISA to preclude patients from bringing federal actions directly against MCOs.<sup>14</sup> As a result, ERISA has left patients no recourse while it has left MCOs free to make treatment decisions in the interest of profit rather than in the interest of their patients.<sup>15</sup>

Recently, the United States Supreme Court in *Pegram v. Herdrich*<sup>16</sup> further insulated HMOs from liability under ERISA when it denied a beneficiary's claim for breach of an ERISA fiduciary duty against her HMO based on the HMO's use of financial incentive arrangements with its providers. In rendering its decision, the Supreme Court failed to utilize the statutory resources Congress provided when it enacted ERISA, resources that would have enabled the Supreme Court to find an MCO liable for breach of its fiduciary duty. Consequently, the Court's decision in *Pegram* reinforced — unnecessarily and unfortunately — the protections from liability afforded to financially self-interested MCOs.

This Note advocates changing that result. MCOs, as fiduciaries, should be liable when MCO physicians fail to provide patients the quality of care they deserve as a result of the MCOs' cost-cutting efforts. Part II provides essential background of ERISA and explains the tensions between ERISA and managed care, and provides a description of the facts and legal analysis in *Pegram*. Part III examines the Supreme Court's decision in *Pegram* and explains how the Court blatantly abdicated its judicial law-creating authority by failing to recognize the fiduciary obligation as a legitimate avenue of ERISA liability against MCOs. Finally, Part IV discusses the effect that the Court's abdication will have on the future of the medical industry.

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12. See 29 U.S.C. § 1144(a) (1994) (stating that the Act "shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan").

13. ERISA provides no explicit federal cause of action against MCOs. See discussion of ERISA *infra* notes 34-47 and accompanying text.

14. See *infra* discussion accompanying notes 48-59.

15. This Note recognizes that not all claims against MCOs are governed by ERISA. A vast majority of federal remedies against MCOs, however, are governed by ERISA because a vast majority of Americans receive their healthcare through an employee benefit plan.

16. 530 U.S. 211, 120 S. Ct. 2143 (2000).

## II. BACKGROUND

### A. The Emerging Conflict Between ERISA and Managed Care

The increase in malpractice lawsuits against health care entities occurred relatively recently in the United States.<sup>17</sup> For decades, the health care market consisted mainly of self-employed physicians running their own practices or practicing in small groups.<sup>18</sup> These physicians provided fee-for-service care, by which physicians received direct payments for every procedure they deemed medically necessary.<sup>19</sup> Physicians had direct control over the health care services provided to patients, and malpractice lawsuits therefore focused on the physician rather than the hospital.<sup>20</sup>

Fewer physicians continued to practice independently after Congress passed the HMOA.<sup>21</sup> This change, however, did not occur overnight. It was not until the 1980s that the market recognized managed care organizations as an effective system to drive down the escalating price of health care.<sup>22</sup> Managed care organizations reduced costs because they competed within the health care market to drive down the high price of health care.<sup>23</sup> Over time, the escalating costs for health

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17. See Noah, *supra* note 10, at 1230-1231.

18. See Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 227 (1999) ("[p]hysicians were traditionally independent decision makers, operating for their own self-interest, either as sole proprietors or in small partnerships").

19. *Id.* at 227 ("[t]raditional fee-for-service medicine, paid for with indemnity insurance plans that paid for all care that the patient's physician deemed medically necessary had several checks and balances that operated to protect the quality of patient care"). Fee-for-service medicine incited physicians to provide more rather than less care because they were paid regardless of the cost. See *id.*

20. See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medicare Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 382 (1994).

21. See 42 U.S.C. § 300e (1994).

22. See WENDY KNIGHT, *MANAGED CARE: WHAT IT IS AND HOW IT WORKS* 6 (1998) (discussing the factors in the late 1960s and early 1970s that caused health care costs to exceed the overall Consumer Price Index ("CPI"); see also Pittman, *supra* note 8, at 356 (stating that the cost of health care in the United States is of national concern).

23. There are two basic models of MCOs, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). HMOs generally furnish both primary care and hospital-based acute care over a specified period to subscribers who prepay a set fee. This enrollment fee remains set regardless of the actual costs of services. The inherent risk with HMOs is that the actual costs of the services utilized by the subscriber will be more than the enrollment fee. See Noah, *supra* note 10, at 1223-25 (citing DONALD K. FREEBORN & CLYDE R. POPE, *PROMISE AND PERFORMANCE IN MANAGED CARE: THE PREPAID GROUP PRACTICE MODEL* 20-21 (1994)). PPOs negotiate with physicians or hospitals at dis-

care drove employers, who understood the value of maintaining a healthy workforce, to utilize managed health care.<sup>24</sup> As enrollment in managed care increased,<sup>25</sup> physicians relinquished their independence to work collectively for the MCOs.<sup>26</sup>

The HMOA cut costs by changing the medical industry's payment system from fee-for-service to fixed-fee.<sup>27</sup> Unlike the fee-for-service system, the fixed-fee system limits reimbursement for medical care services to the fixed amount received for each patient.<sup>28</sup> MCOs, therefore, take steps to control costs, such as issuing reports to their physicians about appropriate levels of care.<sup>29</sup> In addition, many MCOs have implemented utilization reviews<sup>30</sup> and financial incentives as means to reduce the cost of providing care.<sup>31</sup> MCOs make coverage decisions when they compare the requested services against the plan's

counted fee-for-service rates. Subscribers pay the PPO premiums and the PPO reimburses the participating physicians and hospitals for their services. *See id.* at 1225.

24. *See* Roland, *supra* note 5, at 1497; Noah, *supra* note 10, at 1221 (noting that medical spending increased at an average annual rate of 4.8% between 1960 and 1993, which, combined with other economic factors, led to the emergence of managed care as a response to the escalating cost of receiving health care services).
25. *See* Ellyn Spragins, *Does Your HMO Stack Up?*, NEWSWEEK, June 24, 1996, at 56 (stating that 53.3 million people were enrolled in HMOs in 1995, up from 6 million in 1976, and projecting that enrollment in HMOs would reach 103.2 million by the year 2000).
26. *See* Noah, *supra* note 10, at 1219 (citing GENIE JAMES, MAKING MANAGED CARE WORK 93 (1997))(stating that more than three quarters of physicians in the United States practice within some form of MCO or see managed care patients).
27. *See* ROSENBLATT ET AL., *supra* note 7, at 543-46 (explaining the change from the fee-for-service system to managed care); Andrea K. Marsh, Note, *Sacrificing Patients for Profits: Physician Incentives to Limit Care and ERISA Fiduciary Duty*, 77 WASH. U. L.Q. 1323, 1327-28 (1999)(stating that the managed care system arose in response to escalating concerns about the fee-for-service system and rising health care costs).
28. As one court clarified:  

A health maintenance organization . . . offers, for a fixed fee, as much medical care as the patient needs. Providers using traditional fee-for-service methods, by contrast, charge for each procedure. . . . a physician receiving a fee for each service has an incentive to run up the bill by furnishing unnecessary care, and an [MCO] has an incentive to skimp on care (once patients have signed up and paid) in order to save costs.

*Anderson v. Humana, Inc.*, 24 F.3d 889, 890 (7th Cir. 1994).
29. *See* ROSENBLATT ET AL., *supra* note 7, at 568-70.
30. *See* Lancaster v. Kaiser Found. Health Plan, 958 F. Supp. 1137, 1147 (E.D. Va. 1997)(describing utilization review as "the use of an independent or third-party reviewer who evaluates a physician's medical decisions to determine the necessity and cost-effectiveness of the recommended approach prior to hospitalization or treatment").
31. *See id.* at 1147 (describing an incentive program as "bonuses to physicians who refrain from ordering so-called "unnecessary" referrals or "unwarranted" diagnostic tests"); *see also* ROSENBLATT ET AL., *supra* note 7, at 563-65.

contractual terms to ensure that the request falls within the scope of covered events.<sup>32</sup>

While the high price of health care concerned Congress in the early 1970s, the improvident management of employee pension plans was also of concern.<sup>33</sup> Thus, less than a year after Congress adopted the HMOA, Congress passed ERISA.<sup>34</sup> Congress hoped that ERISA would protect employees and their families from pension funding abuses.<sup>35</sup> Congress planned to establish standards of conduct for fiduciaries of employee benefit plans.<sup>36</sup>

Congress enacted ERISA with the ancillary goal of creating a uniform set of federal regulations to govern claims against employee benefit plans.<sup>37</sup> Consequently, Congress designed ERISA with a preemption clause requiring state courts to remove to federal court "any or all State laws" that "relate to" an employee benefit plan.<sup>38</sup> Until 1994, courts had consistently interpreted ERISA's preemption clause broadly, preempting most state tort actions challenging the quality of care against MCOs.<sup>39</sup> In fact, in *Shaw v. Delta Air Lines*,<sup>40</sup>

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32. See *Pegram v. Herdrich*, 530 U.S. 211, \_\_\_, 120 S. Ct. 2143, 2149 (2000).

33. See Roland, *supra* note 5, at 1493 ("Congress enacted ERISA in large part due to the injustices many Americans suffered when they spent their lives working and saving only to find at retirement that their pension funds were insolvent"); see also Locke, *supra* note 9, at 1036 (citing H.R. Rep. No. 93-533, at 3-4 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4642).

34. See generally *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

35. See *Varity Corp. v. Howe*, 516 U.S. 489, 496 (1996).

36. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).

37. See Pittman, *supra* note 8, at 360 (stating that "the use of ERISA's preemption clause to protect employers and ERISA benefit plans from conflicting state laws is only an ancillary purpose to the primary purpose of protecting employees' benefits from the employers' administrative and funding abuses."); Richards, *supra* note 18, at 223 (citing EDWARD P. RICHARDS & KATHARINE C. RATHBUN, *MEDICAL CARE LAW* (1999)) (stating that Congress wanted to allow multi-state companies to sign uniform labor agreements across all state lines since, before ERISA, multi-state corporations had to offer different health insurance plans because of the differences in state laws regulating insurance); see also *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (finding that federal regulations preempt state laws regarding employee benefit plans).

38. See 29 U.S.C. § 1144(a); Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising From Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L.J. 155, 207-16 (1997) (discussing cases that outline the application of ERISA's preemptive "relate to" language).

39. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) ("Where, as here, Congress has expressly included a broadly worded pre-emption provision in a comprehensive statute such as ERISA, our task of discerning congressional intent is considerably simplified."); *FMC Corp. v. Holliday*, 498 U.S. at 58 ("The pre-emption clause is conspicuous for its breadth."); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41-46 (1987) ("We have observed in the past that the express preemption provisions of ERISA are deliberately expansive. . . ."); *Shea v. Esenstein*, 107 F.3d 625, 627 (8th Cir. 1997) (stating that "the language of ERISA's



the Supreme Court held that a law "relates to" a plan if it merely has a "connection with or reference to a plan."<sup>41</sup> In *Shaw*, ERISA plan beneficiaries argued that ERISA did not preempt a New York statute that required employee benefit plans to provide sick leave benefits to pregnant women upon their request.<sup>42</sup> The Court broadly interpreted ERISA's preemption clause, noting that it would give effect to the "relates to" language in the normal sense of the phrase, unless there was good reason to believe that Congress intended the language to have some more restrictive meaning.<sup>43</sup> The Court examined the requirements of the New York statute and determined that requiring employers to provide employees with specific benefits clearly "relates to" benefit plans.<sup>44</sup> The Court pointed out that ERISA's legislative history supported its decision to preempt the New York statute.<sup>45</sup> According to the Court, Congress rejected an early version of the preemption clause, which limited preemption to the subject matters covered by ERISA, replacing it with the present language.<sup>46</sup> The Court decided that this indicated a Congressional intent to apply ERISA's preemption clause broadly.<sup>47</sup>

Meanwhile, beneficiaries denied redress against their MCOs in state court due to ERISA's expansive preemption clause attempted to open other avenues of liability under ERISA. The development of common-law claims against health care plans began in 1986 with the California decision in *Wickline v. State*.<sup>48</sup> *Wickline* introduced two tort theories of liability against health benefit plans — direct and vicarious liability.<sup>49</sup> Vicarious liability holds the MCO liable for the negligence of its employees.<sup>50</sup> Under direct liability, the MCO is directly liable for any injury to its patients.<sup>51</sup> Federal courts followed by recognizing claims for vicarious liability.<sup>52</sup> However, federal courts

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preemption clause sweeps broadly, embracing common law causes of action if they have a connection with or reference to an ERISA plan.").

40. 463 U.S. 85, 96-97 (1983).

41. *Id.*

42. *See id.* at 88-93.

43. *See id.* at 96-97.

44. *Id.* at 100.

45. *See id.* at 98-100.

46. *See id.* at 98.

47. *See id.* at 99-100.

48. 239 Cal. Rptr. 810 (Ct. App. 1986)(involving an ERISA plan that denied a beneficiary authorization for a longer hospital stay after post-surgical complications developed, requiring amputation of the patient's leg).

49. *See id.* at 819.

50. *See Locke, supra* note 9, at 1035.

51. *See id.*

52. *See, e.g., Dukes v. U.S. Healthcare*, 57 F.3d 350, 356 (3d Cir. 1995)(holding that plaintiff's vicarious liability malpractice claim against U.S. Healthcare was not preempted by ERISA); *Locke, supra* note 9, at 1037 (stating that despite ERISA preemption, patients have had some success when bringing vicarious liability

have consistently denied claims against MCOs for direct liability due to the preemptive effect of ERISA.<sup>53</sup> Not surprisingly, beneficiaries who have been denied relief in federal court after having their claims preempted by ERISA have grown frustrated with ERISA's preemption clause.

For example, in *Corcoran v. United HealthCare*,<sup>54</sup> the Fifth Circuit held that ERISA preempted a medical malpractice claim against the third-party plan administrator, United HealthCare, for coverage decisions it made under its "pre-certification" review program.<sup>55</sup> United decided against hospitalizing Corcoran during her high-risk pregnancy and her unborn child died as a result.<sup>56</sup> The Fifth Circuit reasoned that the decision not to hospitalize her involved a benefit determination, bringing it under the guise of ERISA and preempting the claim as one "relating to" benefits.<sup>57</sup> After exhausting all their arguments to stay out of federal court, the Corcorans dropped their malpractice claim and pressed their claim directly under ERISA.<sup>58</sup> The Fifth Circuit, however, held that "the result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake."<sup>59</sup> Thus, beneficiaries cannot redress their injuries against MCOs under ERISA because ERISA offers no explicit cause of action against MCOs, preempting state laws that might subject MCOs to liability.

Subsequently, in *Kuhl v. Lincoln National Health Plan*,<sup>60</sup> the Eighth Circuit held that ERISA preempted the Kuhl's state medical malpractice claim against Mr. Kuhl's plan administrator. Buddy Kuhl

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claims against MCOs). There are two main theories of vicarious liability: 1) respondeat superior, where an employer-employee relationship exists between the HMO and physician, and the physician's negligent behavior fell within the scope of her employment, and 2) ostensible agency, where the patient relies on the MCO's representation that the physician is its agent or employee, and the MCO will be vicariously liable for the acts of the physician even if the physician turns out to be an independent contractor. *See id.* at 1034 nn.38-39.

53. *See* discussion of ERISA preemption *supra* notes 38-47; *see also* *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (finding that the complete preemption doctrine applied to plaintiff's negligence claims against the pre-certification review administrator who had denied her request for physical therapy to rehabilitate her knee subsequent to surgery); *Tolton v. American Biodyne*, 48 F.3d 937 (6th Cir. 1995) (holding that ERISA preempted Mr. Tolton's family's wrongful death, improper refusal to authorize benefits, insurance bad faith, and medical malpractice claims because they stemmed from benefit determinations made by his health plan).

54. 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992).

55. *See id.* at 1334.

56. *See id.* at 1322-23.

57. *See id.* at 1331.

58. *See id.* at 1334-36.

59. *Id.* at 1338.

60. 999 F.2d 298, 304 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994).

was an employee of Belger, a company that offers its employees a health plan through Lincoln National.<sup>61</sup> Lincoln National paid independent physicians, hospitals, and other health care providers to render medical services for its members.<sup>62</sup> Lincoln National then determined whether the Belger plan covers a particular procedure or hospitalization.<sup>63</sup> When Buddy Kuhl suffered a heart attack, his primary care physician placed him in the care of a heart specialist who concluded that surgery was necessary.<sup>64</sup> Lincoln National then arranged for a second opinion, which confirmed that Buddy needed surgery "in the next few weeks."<sup>65</sup> Lincoln National, however, refused to pre-certify the surgery because the doctor had scheduled the surgery outside of Lincoln National's service area.<sup>66</sup> By the time Lincoln National authorized surgery, Kuhl's heart had deteriorated to a point that surgery was no longer an option.<sup>67</sup> Even though Lincoln National refused to pay the expenses, the doctors placed Kuhl on a heart transplant list.<sup>68</sup> Unfortunately, he died while waiting.<sup>69</sup> The Eighth Circuit reasoned that because delaying pre-certification of heart surgery arose from administration of benefits, it must be preempted by ERISA.<sup>70</sup> Ultimately, the Kuhls were denied redress in federal court because the Eighth Circuit determined that the Kuhls' factual allegations did not state a claim under ERISA.<sup>71</sup>

As ERISA's expansive preemption clause continually denied patients recourse in federal court, the United States Supreme Court decided to revisit the scope of the preemption clause in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*.<sup>72</sup> In *Travelers*, the plaintiffs challenged a New York statute that imposed a surcharge on fees charged to patients whose commercial insurance coverage is purchased by an employee health care plan governed by ERISA.<sup>73</sup> The statute imposes surcharges on health maintenance organizations if their membership fees paid by an ERISA plan did not "relate to" employee benefit plans within the mean-

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61. See *id.* at 299-300.

62. See *id.* at 299.

63. See *id.*

64. See *id.* at 300.

65. *Id.*

66. See *id.*

67. See *id.*

68. See *id.*

69. See *id.*

70. See *id.* at 304.

71. See *id.*

72. 514 U.S. 645 (1995). Although *Travelers* did not address ERISA preemption in the context of patient claims directly against negligent MCOs, the Court's opinion offers insight into the inconsistencies between the language and purpose of the statute. See Locke, *supra* note 9, at 1040.

73. See 514 U.S. at 649-50.

ing of ERISA's preemption clause.<sup>74</sup> The Court examined ERISA's objectives to determine the scope of ERISA's preemption of state law.<sup>75</sup> It noted that the basic purpose of preemption was to create uniform law to govern employee benefit plans.<sup>76</sup> In contrast, New York's statute imposes surcharges to equalize the price of premiums among insurance providers so that one does not have a price advantage over another.<sup>77</sup> The court noted that cost uniformity was not an object of preemption and that ERISA did not mean to bar such indirect influences under state law.<sup>78</sup> It resolved that ERISA only preempts state laws that impose unacceptable burdens on a plan, such as mandating benefit structures or their administration, or providing alternate enforcement mechanisms.<sup>79</sup> As such, the Court held that ERISA did not preempt the statute in question.<sup>80</sup>

*Travelers* was the Court's first step in retreat from its broad interpretation of the "relates to" language of the ERISA preemption clause. Thereafter, courts began recognizing additional kinds of claims as not preempted under ERISA. For example, the Fifth Circuit in *Jamail, Inc., v. Carpenters District Council of Houston Pension & Welfare Trusts*,<sup>81</sup> allowed an employer to assert a federal common law cause of action for restitution for excessive contributions to an ERISA plan. In *Provident Life & Accident Insurance Co. v. Waller*,<sup>82</sup> the Fourth Circuit created a federal common law cause of action for unjust enrichment, despite the absence of such a remedy in ERISA's statutory language.

The Supreme Court even seemed to expand the scope of the ERISA fiduciary cause of action with its decision in *Varity Corp. v. Howe*.<sup>83</sup> One of the few theories of liability available under ERISA is the fiduciary cause of action. ERISA requires plan fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries."<sup>84</sup> In *Varity*, the Supreme Court addressed the issue of whether beneficiaries could assert breach of fiduciary duty

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74. *See id.*

75. *See id.* at 655.

76. *See id.* at 656-57.

77. *See id.* at 685-59.

78. *Id.* at 661.

79. *See id.* at 658.

80. *See id.* at 662. The Court reasoned that the surcharge's effect on providing hospital benefits posed only an indirect economic effect that did not bind plan administrators to any particular benefits choice. *Id.* at 668.

81. 954 F.2d 299, 303-06 (5th Cir. 1992).

82. 906 F.2d 985, 987-88, 992-94 (4th Cir.), *cert. denied*, 498 U.S. 982 (1990).

83. 516 U.S. 489 (1996).

84. 29 U.S.C. § 1001(b).

claims to obtain individual rather than plan-wide relief.<sup>85</sup> The Supreme Court held that beneficiaries could assert individual claims for equitable relief under 29 U.S.C. § 1132 (a)(3)(B), which redresses breaches of fiduciary duty provided that no "other appropriate equitable relief" is available under any of ERISA's other civil enforcement provisions.<sup>86</sup> Varity Corporation decided to transfer money-losing divisions of one of its subsidiaries to another.<sup>87</sup> When it did this, Varity Corporation tried to persuade employees of the failing divisions to change employers and benefit plans.<sup>88</sup> Varity Corporation assured employees that their benefits would remain secure in the transfer.<sup>89</sup> However, the employees who transferred lost their nonpension benefits. Those employees sued Varity Corporation under ERISA claiming that Varity purposefully misled them into forfeiting their benefits.<sup>90</sup> The District Court found that Varity and the money-losing subsidiary were fiduciaries under ERISA. By harming the employees, they violated their ERISA fiduciary duty.<sup>91</sup> The Eighth Circuit Court of Appeals affirmed in relevant part.<sup>92</sup> On certiorari, the United States Supreme Court held that Varity was acting as a fiduciary when it purposefully misled the employees about the security of their benefits because, in so doing, Varity exercised "discretionary authority" in the administration of the employee benefit plan.<sup>93</sup> Then, the Court found that Varity breached its fiduciary duty because deceiving beneficiaries to make money for the employer is not an action "solely in the interest of the participants and beneficiaries."<sup>94</sup> Finally, the Court recognized a fiduciary cause of action by individuals under ERISA.<sup>95</sup>

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85. See 516 U.S. at 509-10. Courts have disputed whether ERISA's civil enforcement provisions afford individual relief for fiduciary breaches. 29 U.S.C. § 1132 (a)(3)(B), [Section 502(a)(3)] provides:

A civil action may be brought—

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(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

*Id.*

86. 29 U.S.C. § 1001(b).

87. See 516 U.S. 489, 493.

88. See *id.*

89. See *id.* at 494.

90. See *id.*

91. See *id.*

92. See *id.* at 495.

93. See *id.* at 502-05.

94. *Id.* at 506-07.

95. See *id.* at 507-515.

The Court based its decision to recognize a fiduciary cause of action under ERISA for individuals on § 502(a)(3) of ERISA,<sup>96</sup> which allows lawsuits for individual equitable relief for breach of fiduciary duties. The Court distinguished its decision in *Massachusetts Mutual Life Insurance Co. v. Russell*,<sup>97</sup> where it held that § 502(a)(2) of ERISA<sup>98</sup> does not provide individual relief. It reasoned that the restriction under subsection (2) does not mean that such relief is not "appropriate" under subsection (3).<sup>99</sup> Since the Supreme Court's decision in *Varity*, participants seeking individual relief for breaches of fiduciary duty have flooded the courts.<sup>100</sup>

For example, the Eighth Circuit held in *Shea v. Esensten*<sup>101</sup> that ERISA imposes a fiduciary duty on plan physicians and administrators to disclose the existence and nature of financial incentives used to affect physicians' medical decision-making.<sup>102</sup> Shea died of heart failure just a few months after his doctor refused to refer Shea to a cardiologist, despite warning signs that Shea's heart was diseased.<sup>103</sup> Shea's widow sued the HMO for failure to disclose that it offered financial incentives for physicians to limit care.<sup>104</sup> Specifically, Shea's HMO rewarded doctors for not making covered referrals to specialists and the HMO reduced the doctors' fees if they made too many.<sup>105</sup> The court relied on *Varity* and held that HMOs must disclose to their patients the existence of financial incentives to limit care.<sup>106</sup> It reasoned that the fiduciary duty detailed by the Supreme Court in *Varity* clearly could have included an obligation to disclose the "material fact" of physician incentives.<sup>107</sup>

## B. Case-in-Point

Cynthia Herdrich represents yet another patient who tried to assert breach of fiduciary responsibility under ERISA after ERISA preempted her other claims.<sup>108</sup> On March 1, 1991, Herdrich experienced

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96. Codified at 29 U.S.C. § 1132(a)(3) (1994).

97. 473 U.S. 134 (1985).

98. Codified at 29 U.S.C. § 1132(a)(2) (1994).

99. See *Varity*, 516 U.S. at 495.

100. See *Courts Dismiss Claims For Benefits Clothed as Breaches of Fiduciary Duty* (McDermott, Will & Emery, ERISA Litigation Review)(visited July 12, 2000) <<http://www.mwe.com/news/eris0398.htm>>.

101. 107 F.3d 625 (8th Cir. 1997).

102. See *id.* at 629.

103. See *id.* at 626.

104. See *id.* at 627.

105. See *id.*

106. See *id.* at 627-28.

107. See 107 F.3d 625, 628.

108. See *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *rev'd*, *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143 (2000).

pain in the midline area of her groin.<sup>109</sup> Herdrich visited her health plan provider, Carle,<sup>110</sup> where Dr. Lori Pegram examined her.<sup>111</sup> Six days later, at a second exam, Dr. Pegram found an inflamed mass in Herdrich's abdomen.<sup>112</sup> Dr. Pegram decided that Herdrich would have to wait eight more days before ordering an ultrasound to diagnose the problem.<sup>113</sup> In so doing, Dr. Pegram ordered the procedure at a facility staffed by Carle more than fifty miles away.<sup>114</sup> Not even eight days had passed when Herdrich's appendix ruptured.<sup>115</sup> As a result, Herdrich suffered the life-threatening condition, peritonitis, which required additional surgery.<sup>116</sup>

Herdrich sued Dr. Pegram and her health plan provider, Carle, for medical negligence in Illinois state court.<sup>117</sup> Later, she added two counts of state-law fraud against Carle and Health Alliance Medical Plans, Inc. ("HAMP").<sup>118</sup> Carle contended that ERISA preempted the fraud claims.<sup>119</sup> Consequently, the district court removed the case to federal court.<sup>120</sup> Carle then sought summary judgment on the state-law fraud counts.<sup>121</sup> The district court granted summary judgment to Carle on the second state-fraud count, but granted Herdrich leave to amend the other state-law fraud count.<sup>122</sup> In her amended complaint, Herdrich alleged that the provision of medical services under the terms of the Carle HMO plan, rewarding physician-owners who lim-

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109. *See id.* at 365 n.1.

110. Petitioners, Carle Clinic Association, P.C., Health Alliance Medical Plans, Inc., and Carle Health Insurance Management Co., Inc. (collectively "Carle") were the health maintenance organization ("HMO") that provided Herdrich with medical care through her husband's employer, State Farm Insurance. Carle functions as an HMO owned by physicians providing prepaid medical services to participants whose employers contract with Carle for coverage. *See id.* at 365.

111. *See id.* at 365 n.1.

112. *See id.*

113. *See id.* at 374.

114. *See id.* Herdrich's health plan required patients in "non-emergency" situations to receive care from facilities owned by the plan. Herdrich's health plan classified her condition as a "non-emergency" and required that she visit a plan-owned facility fifty miles from her neighborhood hospital.

115. *See id.*

116. *See id.*

117. *See id.* at 365. Although Dr. Pegram was listed as a petitioner, it was "unclear to [the Court] that she retain[ed] a direct interest in the outcome of th[e] case. *Pegram v. Herdrich*, 530 U.S. 211, \_\_\_, 120 S. Ct. 2143, 2144 n.1. (2000).

118. *See Herdrich*, 154 F.3d at 365.

119. *See id.*

120. *See id.* at 366. ERISA governs all benefit plans sponsored by employers. ERISA broadly preempts state law actions in the area of employee benefits. *See* 29 U.S.C. § 1144(a).

121. *See id.*

122. *See id.* The district court granted summary judgment against Herdrich on Count IV "to the extent [she] relies on 502(a)(3)(B) [of ERISA, codified at 29 U.S.C. § 1132(a)(3)(B)] as a basis for monetary relief, as opposed to equitable relief." *Id.*

ited medical care, constituted an anticipatory breach of an ERISA fiduciary duty.<sup>123</sup> In support, Herdrich reasoned that the plan's contractual terms incited physicians to make decisions in their own best interests, rather than in the exclusive interests of the patients who participate in the plan, thus violating their fiduciary responsibility.<sup>124</sup>

Despite Herdrich's new argument, the district court granted summary judgment to Carle, holding that Carle was never "involved [in these events] as" an ERISA fiduciary.<sup>125</sup> Herdrich prevailed, however, on her malpractice counts, receiving \$35,000 for her injuries.<sup>126</sup> Herdrich appealed the district court's dismissal of her ERISA-based claim to the Seventh Circuit Court of Appeals.<sup>127</sup> The Seventh Circuit reversed the district court's decision, holding that Carle was acting as a fiduciary when its physician decided to postpone the needed treatment.<sup>128</sup>

The United States Supreme Court reversed the Seventh Circuit Court of Appeals decision.<sup>129</sup> It held that mixed eligibility and treatment decisions by HMO physicians do not constitute fiduciary decisions under ERISA.<sup>130</sup> The Supreme Court supported incentive schemes, emphasizing that no HMO would survive without incentives connecting physician reward with treatment rationing.<sup>131</sup> Thus, it refused to distinguish between good and bad HMO incentive schemes, noting such action would involve a judgment about the level of socially

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123. *See id.* at 366 & n.3.

124. *See id.* The ERISA statute, under which Herdrich sought relief provides that:

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

29 U.S.C. § 1109(a).

125. *Herdrich*, 154 F.3d at 367.

126. *See id.* at 367.

127. *See id.*

128. *See id.* at 380. The Seventh Circuit reasoned that

[o]ur decision does not stand for the proposition that the existence of incentives *automatically* gives rise to a breach of fiduciary duty. Rather, we hold that incentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

*Id.* at 373.

129. *See Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143 (2000).

130. *See* 120 S. Ct. at 2155, 2158.

131. *See id.* at 2150.



accepted medical risk for the sake of reducing cost.<sup>132</sup> According to the court, such a decision would turn on facts not readily available to courts.<sup>133</sup> Further, the Court explained that Congress had not intended for an HMO to be treated as a fiduciary under ERISA when it makes mixed eligibility and treatment decisions through its physicians.<sup>134</sup> It reasoned that trustees' duties under the common law of trusts would be inconsistent with HMO physicians' duties because HMO physicians may have to pay out money not in the best interest of the beneficiary.<sup>135</sup> It further reasoned that subjecting HMOs to limited fiduciary liability as suggested by the Seventh Circuit would simply turn into a slippery slope of malpractice claims and undermine their very purpose in the medical industry—to reduce medical costs.<sup>136</sup>

### III. ANALYSIS: THE SUPREME COURT'S DECISION IN *PEGRAM*

The United States Supreme Court failed to exercise its authority under ERISA when it refused to acknowledge a breach of fiduciary duty by MCOs that financially induce physicians to deny needed healthcare services.<sup>137</sup> In so doing, the Court wiggled its way through ERISA's broad language dodging the profoundly important cause of action.<sup>138</sup>

The Supreme Court in *Pegram* held that mixed treatment and eligibility decisions do not constitute fiduciary decisions under ERISA.<sup>139</sup> In support of its decision, the Court reasoned that Congress

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132. See *id.* at 2150-51.

133. See *id.* at 2150, 2157.

134. See *id.* at 2155.

135. See *id.* at 2155-56.

136. See *id.* at 2157-58.

137. See *Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 24 n.26 (1983)(quoting 120 Cong. Rec. 29, 942 (1974)(statement of Sen. Javits))(noting that ERISA's legislative history suggests that "a body of [f]ederal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans").

138. See *Pittman*, *supra* note 8, at 357 (noting that the "Court has punched a zone of no liability for negligent acts committed while under an ERISA plan in an important federal statute that affects the lives of millions of employees and beneficiaries" when it refused "to exercise its authority under ERISA to create federal common law remedies to replace preempted state laws.")

139. See *Pegram*, 530 U.S. at \_\_\_, 120 S. Ct. at 2143. The Court defined pure "eligibility decisions" as decisions regarding the "plan's coverage of a particular condition or medical procedure for its treatment." 120 S. Ct. at 2154. The Court defined "[t]reatment decisions" as "choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" *Id.* The Court further stated that treatment and eligibility decisions are "practically inextricable from one another." *Id.* The Court alluded to the fact that pure eligibility decisions could be considered fiduci-

had not intended to treat HMOs as ERISA fiduciaries to the extent that they make mixed eligibility decisions through their physicians.<sup>140</sup> The Supreme Court's decision in *Pegram*, however, defied the very purpose behind ERISA by exposing beneficiaries to administrative funding abuses. As discussed below, the Court's decision to shield MCOs from fiduciary liability flies in the face of ERISA's text and legislative history, traditional fiduciary obligations adopted by ERISA, and ERISA's expansive preemptive authority.

## A. ERISA's Text and Legislative History Manifests Congress' Intent for Courts to Hold MCOs Liable as ERISA Fiduciaries

### 1. MCOs Constitute Fiduciaries Under ERISA

According to the plain text of ERISA, a "fiduciary" is someone acting in the capacity of manager, administrator, or financial adviser to the extent that they exercise "any discretionary authority or discretionary responsibility in the administration" of an ERISA plan.<sup>141</sup> In light of this statutory language, courts have interpreted "fiduciary" functionally, rather than formally, in terms of the party's control and authority over the plan and benefits.<sup>142</sup> Pursuant to this functional interpretation, federal courts have found that an MCO exercising discretion and control over the administration or management of the benefits plan acts as a fiduciary for purposes of ERISA.<sup>143</sup> An MCO

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ary in nature, but that Herdrich failed to allege any breach of a pure eligibility decision. *See id.*

140. *See id.* at 2155. When an MCO induces physicians to limit patient care through financial incentive schemes, physicians must inherently make decisions that constitute both the practice of medicine (treatment decisions) and discretionary administration of plan benefits (eligibility decisions). Normally, physicians would only be held to making treatment decisions, but financial incentives place an additional burden on physicians to reduce costs as well, which goes to eligibility decisions, not care decisions.

141. *See* 29 U.S.C. §§ 1002(21)(A)(i)-(iii). These sections provide that:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or (iii) he has any discretionary authority or responsibility in the administration of such plan.

*Id.*

142. *See* *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993) (establishing that the test for determining whether a given person or entity is a fiduciary with respect to the plan hinges on the person's or entity's actions and not the official designation of the person or entity's role).
143. *See, e.g.,* *Shea v. Esensten*, 107 F.3d 625, 628-29 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997); *O'Reilly v. Ceuleers*, 912 F.2d 1383, 1385 (11th Cir. 1990); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 751 (S.D.N.Y. 1997).

exercises its "discretionary authority" or "responsibility" when it determines whether a patient is entitled to healthcare benefits.<sup>144</sup>

In addition to its text, ERISA's legislative history confirms that Congress purposefully construed ERISA's interpretation of "fiduciary" liberally to encompass MCOs.<sup>145</sup> Chairman of the House Committee on Education and Labor in 1974 recited the following broad interpretation of "fiduciary:"

The Committee has adopted the view that the definition of fiduciary is of necessity broad. . . . A fiduciary need not be a person with direct access to the assets of the plan. . . . Conduct alone may in appropriate circumstances impose fiduciary obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary.<sup>146</sup>

Still, courts do not need to interpret "fiduciary" broadly to merely apply the fiduciary status to MCOs. As stated, a "fiduciary" exercises discretionary authority over a plan.<sup>147</sup> MCOs by their very nature make discretionary plan decisions when they determine which tests or treatments are appropriate for a particular patient in a particular situation.<sup>148</sup> These discretionary activities are precisely the kind to which the traditional fiduciary standard of responsibility applies.<sup>149</sup>

At the time Congress enacted ERISA, it could not have envisioned the specific provisions required to protect consumers of managed health care from dangerous cost-saving innovations.<sup>150</sup> Congress accordingly drafted ERISA with broad language to allow courts to continually interpret ERISA to best effectuate Congress' intent of protecting beneficiaries from funding abuses.<sup>151</sup> One commentator even noted that the body of law governing fiduciaries in particular

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144. See cases cited *supra* note 143.

145. Although ERISA's legislative history did not specifically mention MCOs, commentators have determined that because of its broad, encompassing language, Congress intended for ERISA to adapt to the changes in the medical system. See Dahlia Schwartz, *Breathing Lessons for the ERISA Vacuum: Toward a Reconciliation of ERISA's Competing Objectives in the Health Benefits Arena*, 79 B.U. L. REV. 631 (1999)(discussing the broad language of ERISA and the need for courts to interpret it according to congressional intent).

146. *Herdrich v. Pegram*, 154 F.3d 362, 370 (7th Cir. 1998)(quoting 120 CONG. REC. 3977, 3983 (daily ed. Feb. 25, 1974))(statement of Chairman of the House Committee on Education and Labor, *reprinted in* 2 LEGISLATIVE HISTORY OF THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974, at 3293).

147. See *supra* note 141 and accompanying text.

148. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1330 n.13 (5th Cir. 1992)(noting that discretionary authority over the management of the plan satisfies the statutory definition of fiduciary).

149. See *Libbey-Owens-Ford Co. v. Blue Cross and Blue Shield Mutual of Ohio*, 982 F.2d 1031, 1035 (6th Cir. 1993).

150. See Marsh, *supra* note 27, at 1337.

151. See Schwartz, *supra* note 145, at 638 (explaining that courts construing an ambiguous statute, such as ERISA, must look first to congressional intent).

should evolve to fit changes in societal structure.<sup>152</sup> Physician incentive schemes pose a perfect example of an unforeseen threat to the quality of healthcare.<sup>153</sup> Accordingly, Congress would effectuate its purpose of protecting beneficiaries from funding abuses by recognizing MCOs as having a fiduciary responsibility to its patients. Accordingly, Congress could ensure that MCOs implementing incentive schemes would not sacrifice patient care in their attempt to maximize profits.

## 2. *Financial Incentive Schemes Imposed on Physicians Constitute a Breach of MCOs' Fiduciary Duties*

Under ERISA, plan fiduciaries must act "solely in the interest of the participants and beneficiaries" and for the "exclusive purpose" of "providing benefits" and "defraying reasonable expenses of administering the plan."<sup>154</sup> Courts have interpreted these fiduciary requirements as codifying the common law duty of loyalty imposed by trust law.<sup>155</sup> In a fiduciary relationship, the beneficiary depends on the fiduciary for a particular service.<sup>156</sup> Fiduciary relations are designed only to satisfy the beneficiary's needs.<sup>157</sup> Thus, there is an inherent duty of loyalty to the beneficiary who has entrusted valuable rights to a fiduciary for protection.

The fiduciary responsibility plays an important role in America's medical industry. Fiduciaries must act in the interest of their beneficiaries, which empowers them to use their discretion to decide which of the beneficiaries' risks they should assume.<sup>158</sup> In the medical industry, this translates into health care administrators looking out for its patients' best interests. The fiduciary responsibility is essential to maintain patients' trust in their health care administrator, which benefits society by encouraging patients to utilize preventative methods of care. Thus, to maintain the essential fiduciary role in the medical industry, the health care administrators must respond to the changes in the medical industry—especially the entity most in control of ad-

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152. See Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 798 (1983)(stating that "[l]aw should reflect the changes in societal structure. Thus, a major reason for recognizing and developing a separate body of fiduciary law is that our society is evolving into one based predominantly on fiduciary relations. The body of law governing fiduciary relations can affect and be affected by this social trend.").

153. See *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir. 1993)(noting that an incentive structure where an HMO pays bonuses to physicians who refrain from ordering "unwarranted" diagnostic tests may affect the quantity and quality of benefits provided to a patient under a plan).

154. 29 U.S.C. § 1104(a)(1).

155. See *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1995).

156. See Frankel, *supra* note 152, at 800-801.

157. See *id.*

158. See *id.* at 812.

ministering health care services. Under managed care, MCOs are most in control of administering health care services due to their contractual relationship with both physician employees and the employer-sponsored benefit plans. Subjecting MCOs to fiduciary responsibility would make MCOs accountable for their decisions as health care administrator, a principle of liability well established in the medical industry.

Trust law requires courts to grant a high degree of deference to fiduciaries' decisions under the assumption that the fiduciary is looking out for the best interest of its beneficiary.<sup>159</sup> This level of deference does not apply if a beneficiary can show that the fiduciary acted under a conflict of interest or that the governing law did not, in fact, grant discretionary power to the fiduciary.<sup>160</sup> Because MCOs are in business to make money, it is reasonable for courts to presume that MCOs administering employee benefit plans will face a conflict of interest in carrying out their duty of loyalty to their patients.<sup>161</sup> It is likely that MCOs as ERISA plan fiduciaries will not act with the individual beneficiary's best interests in mind when confronted with the decision of whether to authorize a costly but uncertain treatment.<sup>162</sup> This is because the managed care employment contract with physicians often holds physicians financially responsible for exceeding the capitation limit. Financial incentives imposed on physicians create a very serious conflict between the physician's financial self-interest and the medical interest of the patient. Financial incentives impose a tangible barrier to providing care with an "eye single" to the interest of the beneficiaries.<sup>163</sup> The Supreme Court abdicated its judicial law-making power by not recognizing this as a breach of ERISA's fiduciary duty.

## **B. Fiduciary Obligations Apply to MCOs Whose Physicians Make Mixed Eligibility Decisions as a Result of Financial Incentive Schemes**

The United States Supreme Court in *Pegram* doubted that Congress would have perceived mixed eligibility and treatment decisions as fiduciary decisions when it enacted ERISA.<sup>164</sup> The Supreme Court's doubt arose from the differences between common law trust-

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159. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)(establishing the standard of review for benefit denial cases).

160. See *id.*

161. See *Shea v. Esensten*, 107 F.3d 625, 628 (8th Cir. 1997) (stating that the patient must be informed of whether the advice from her doctor is influenced by self-serving financial considerations created by the MCO).

162. See Schwartz, *supra* note 145, at 657.

163. See *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982).

164. See *Pegram*, 520 U.S. 211, \_\_\_, 120 S. Ct. 2143, 2155 (2000).

ees and MCOs.<sup>165</sup> The *Pegram* Court noted that the payment of money in the interest of the beneficiary was the common law trustee's most defining concern.<sup>166</sup> Accordingly, the Court distinguished the two by noting that MCOs making mixed eligibility decisions do not only pay out money, they consume money as well.<sup>167</sup> The Court further noted that even when MCOs do pay out money, they do not always do it exclusively in the interest of their beneficiaries.<sup>168</sup> The Court concluded that because trust law does not allow fiduciaries to have interests adverse to their beneficiaries,<sup>169</sup> fiduciary obligations under the law of trust do not apply to MCOs whose physicians make mixed eligibility decisions.<sup>170</sup>

The Court's reasoning overlooks Congress' intent to draw a considerable amount, but not all of the ERISA fiduciary material from trust law.<sup>171</sup> While Congress has required courts to *examine* trust principles in determining a party's fiduciary status under ERISA,<sup>172</sup> Congress has also expected courts to interpret ERISA's fiduciary standards bearing in mind the special nature and purpose of employee benefit plans.<sup>173</sup> Courts must acknowledge that the system of managed care has influenced the special nature of employee health benefits.<sup>174</sup> The cost-conscious structure of managed care has influenced

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165. See 120 S. Ct. at 2155-56.

166. See *id.*

167. See *id.* When an MCO induces physicians to limit patient care through financial incentive schemes, physicians must inherently make decisions that constitute both the practice of medicine (treatment decisions) and discretionary administration of plan benefits (eligibility decisions). Treatment decisions have historically been based on the best interest of the beneficiary, while eligibility decisions have historically been based on cost-containment factors.

168. See *id.* at 2156. The Supreme Court admitted that ERISA is rooted in the common law of trusts, but reasoned that MCOs have interests adverse to their beneficiaries, and therefore, could not constitute "fiduciaries" under trust law. *Id.* at 2152.

169. See *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-330 (1981) (stating that the common law of trusts prohibits fiduciaries from holding positions that create conflict of interest with trust beneficiaries).

170. See *Pegram*, 120 S. Ct. at 2158.

171. See S. REP. NO. 93-127 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4865 ("[t]he fiduciary responsibility section, in essence, codifies and make applicable to these fiduciaries certain principles developed in the evolution of the law of trusts"); *Varity*, 516 U.S. at 496; *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985).

172. See *Varity*, 516 U.S. at 506 (noting the relationship between the common law of trusts and ERISA's fiduciary duties).

173. See *id.* at 497 (stating that Congress "expected that the courts will interpret this prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purpose of employee benefit plans," as they "develop a 'federal common law of rights and obligations under ERISA-regulated plans.'") (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987))).

174. See *supra* notes 29-34 and accompanying text.

the special nature of employee benefits by forcing MCO physicians to perform the dual role of plan administrator and medical care provider.<sup>175</sup> Even though the conflict between the goals of ERISA and managed care seems to immunize MCOs from liability, Congress did not intend to totally immunize MCOs from liability *solely because* managed care's goals have conflicted with those of ERISA.<sup>176</sup>

Courts must examine trust law fiduciary obligations in the context of employee benefit plans only to the extent that the MCOs are acting in their fiduciary capacity.<sup>177</sup> MCOs may perform different activities that do not rise to the level of fiduciary.<sup>178</sup> When exercising these roles, MCOs need not concern themselves with whether they are acting adversely to their beneficiaries' interests.<sup>179</sup> Only when MCOs make discretionary decisions must MCOs' activities align with the interests of their beneficiaries.<sup>180</sup> Thus, the liability of fiduciaries under the law of trusts applies to MCOs, but only to the extent they act as fiduciaries. The Court, therefore, seemed to erroneously presume the inapplicability of fiduciary obligations to MCOs solely because their fiduciary responsibilities have been entangled with nonfiduciary activities. As such, the Court ignored congressional intent to interpret the ERISA fiduciary concept broadly to include MCOs, abdicating its judicial law-making authority under ERISA.

### C. ERISA's Broad Preemptive Effect Undermines the Court's Justification for Immunizing MCOs from Liability

The Supreme Court further supported its decision to confer no federal fiduciary cause of action against MCOs under ERISA by noting that beneficiaries can resolve their claims through an alternative venue – state court.<sup>181</sup> While beneficiaries can still impose some state

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175. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995)(discussing the dual treatment/eligibility roles of HMOs).

176. See *supra* notes 44-52 and accompanying text.

177. See 29 U.S.C. § 1002(21)(A)(defining administrator as a fiduciary only "to the extent" that he or she acts in a fiduciary capacity in relation to a plan).

178. See *Pegram*, 120 S. Ct. at 2152 (stating that "[e]mployers, for example, can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries" such as "firing a beneficiary for reasons unrelated to the ERISA plan.").

179. See *Schwartz*, *supra* note 145, at 656 (stating that ERISA fiduciaries need not comply with fiduciary responsibilities when creating, altering, and terminating benefit plans).

180. See HENRY H. PERRITT, JR., *HEALTH CARE LEGISLATION UPDATE AND ANALYSIS*, 58-59 (1995).

181. See *Pegram*, 120 S. Ct. at 2145.

claims against physicians,<sup>182</sup> the Court's reasoning ignores ERISA's expansive preemptive power.

ERISA contains an explicit preemption clause, which provides, in pertinent part, "[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a). . . ."<sup>183</sup> Congress did not specify the scope of "relate to," leaving it ambiguous.<sup>184</sup> Thus, pursuant to Congress' intent to interpret ERISA's language liberally, the Supreme Court has held that ERISA's preemption should be defined broadly.<sup>185</sup>

Federal courts followed the Supreme Court by interpreting the words "relate to" beyond the preemption of state laws relating solely to the specific subjects of ERISA, such as reporting, disclosure, and fiduciary obligations.<sup>186</sup> These courts have construed the phrase more expansively to include state laws that merely have "a connection with or reference to such a plan."<sup>187</sup> In other words, courts have looked beyond the specific duties Congress enumerated in ERISA as being preemptable, and have found that ERISA preempts almost any state law that has anything to do with an employee benefit plan. Because many employers contract with MCOs to provide their employees health care services, courts have consistently found that those contracts qualify as employee benefit plans under ERISA.<sup>188</sup> Thus, almost anyone who qualifies as a beneficiary of an employee benefit plan will have his or her claims against the MCO preempted by ERISA.

Not only do most plans administered by MCOs qualify as employee benefit plans, but also a majority of Americans qualify as ERISA bene-

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182. See Joanne B. Stern, *Malpractice in the Managed Care Industry*, 24 CREIGHTON L. REV. 1285 (1991)(describing the various forms of state liability imposed on MCOs).

183. Pub. L. No. 93-406, 88 Stat. 829, 897 (1974)(codified as amended at 29 U.S.C. § 1144(a)(1994)(emphasis added). According to section 514(c)(1), codified as 29 U.S.C. § 1133(c)(1), the term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. Section 514(b)(2)(A), codified as 29 U.S.C. § 1144(b)(2)(A), exempts certain state laws from preemption.

184. See Schwartz, *supra* note 145, at 638 (explaining that "the inherent tension between the goal of national uniformity of benefit regulation and the need to protect beneficiaries has forced courts to interpret ERISA as if it were an ambiguous statute)(quoting *Travelers*, 514 U.S. 645, 655 (1995)("we must simply go beyond [ERISA's] unhelpful text").

185. See *Shaw*, 463 U.S. at 97 (stating that a law relates to a plan if it has "a connection with or reference to a plan" and is preempted even if it is consistent with ERISA and only indirectly affects employee benefits plans).

186. See discussion *supra* notes 38-42 and accompanying text.

187. See *Shaw*, 463 U.S. at 85.

188. See discussion of ERISA preemption *supra* notes 64-67 and accompanying text.



ficiaries as well, because over one half of Americans now receive their health care through ERISA regulated plans.<sup>189</sup> ERISA preempts Americans' claims against their MCOs simply because they qualify as beneficiaries, leaving them unprotected by state-enforced consumer laws.<sup>190</sup> Beneficiaries must instead resort to the options under federal law, options that do not include suing MCOs who induce physicians to deny care.<sup>191</sup>

Opponents of creating a cause of action against MCOs under ERISA argue that the Supreme Court has since retreated from the very expansive interpretation of the "relates to" language.<sup>192</sup> They argue that more recent courts have held that state law will control claims against MCOs for negligence or low quality of care.<sup>193</sup> However, courts have still preempted direct liability claims against MCOs.<sup>194</sup> Courts have even recently begun recognizing vicarious liability claims against MCOs.<sup>195</sup> These opponents contend that by recognizing vicarious liability, courts have supplied the necessary cause of action against MCOs under ERISA.<sup>196</sup> Thus, they argue that ERISA's "overly broad" preemption clause no longer requires imposing the additional direct liability claims against MCOs.<sup>197</sup>

The opponents' argument, however, fails to recognize that by entangling medical and eligibility decisions, MCOs have made it nearly

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189. See Paul Fronstein, *Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion*, 211 EBRI: Issue Brief 3 (1999) (stating that 64.2% of non-elderly Americans receive their health insurance through an employer).

190. See Roland, *supra* note 5, at 1499.

191. See Richards, *supra* note 18, at 223 (stating that the "central regulatory issue for MCOs is that they are generally exempt from the states' existing system of regulation insurance because of the Employee Retirement Income Security Act ('ERISA')").

192. See *New York State Conf. of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

193. See *Corporate Health Insurance, Inc., v. Montemayor*, 2000 U.S. App. LEXIS 14215, at \*14 (5th Cir., June 20, 2000).

194. See Schwartz, *supra* note 145, at 652 (citing Richard C. Reuben, *In Pursuit of Health*, 82 A.B.A. J. 54, 57 (1996)) (defining direct liability as "negligence committed in the course of administering the benefit plan itself was the proximate cause of the plaintiff's harm.").

195. See, e.g., *Tolton*, 48 F.3d at 943 (holding that wrongful death claims were preempted by ERISA because the plan accused was involved in benefit determinations, recognizing ERISA preemption left participant without meaningful remedies); *Corcoran*, 965 F.2d at 1321 (holding that ERISA preempted wrongful death action for failing to provide adequate benefit coverage); cf. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (holding alleged vicarious liability claims against managed care organization not preempted); *PacificCare of Okla., Inc.*, 59 F.3d 151, 155 (10th Cir. 1995) (holding that ERISA did not preempt a medical malpractice claim against an HMO alleged to be vicariously liable for the malpractice of its physician).

196. See Noah, *supra* note 10, at 1243-44.

197. See Roland, *supra* note 5, at 1501.

impossible to differentiate vicarious from direct liability claims.<sup>198</sup> A direct liability claim against an MCO for denial of treatment based on cost concerns rather than on medical concerns is virtually the same as a vicarious liability claim based on denial of treatment by an MCO physician with poor medical judgment. Each utilize two different methods, but they penalize the same entity. However, ERISA preempts the direct claim, while patients asserting the vicarious liability claim can proceed with a medical malpractice claim in state court.<sup>199</sup>

Moreover, preemption is still very likely in negligence suits linked to financial incentives.<sup>200</sup> ERISA will preempt any claim that challenges the amount of benefits received or administered under an employee benefit plan.<sup>201</sup> Thus, the only tenable claim available against HMOs under ERISA is for breach of fiduciary duty,<sup>202</sup> which the Supreme Court erroneously failed to acknowledge.

#### IV. THE EFFECT OF THE SUPREME COURT'S ABDICATION ON THE FUTURE OF THE MEDICAL INDUSTRY

##### A. Immunizing MCOs from Liability Will Reduce the Quality of Healthcare Services

The actual accomplishments of the managed care system have fallen short of the goals envisioned by Congress in the early 1970s.<sup>203</sup> While Congress expected the competitive arrangements of MCOs to improve the cost efficiency of care, it simultaneously hoped to improve the quality of care.<sup>204</sup> In reality, MCOs have not even achieved substantial cost efficiencies.<sup>205</sup> And, as growing numbers of patients re-

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198. See Wendy K. Mariner, *Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field*, 86 AM. J. PUB. HEALTH 863, 864 (1996).

199. See discussion *supra* notes 43-44 and accompanying text.

200. See Roland, *supra* note 5, at 1500 (discussing how ERISA preempts negligence suits for denials of care linked to financial incentives).

201. See, e.g., *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 125-33 (1992) (holding a municipal law requiring employer to provide health insurance while on workers' compensation comparable to while working was preempted).

202. See Schwartz, *supra* note 145, at 635 (arguing that courts could better serve ERISA's objectives by enforcing the fiduciary obligations ERISA imposes on plan administrators).

203. See Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J. L. & MED. 7, 10 (2000).

204. See *id.*

205. See Pittman, *supra* note 8, at 363 (citing Joseph A. Califano, Jr., *Rationing Health Care: The Unnecessary Solution*, 140 U. PA. L. REV. 1525, 1526 (1992)) (noting that although one study has shown that cost-cutting strategies of MCOs have reduced certain types of health care costs, health care costs continue to rise).

ceive health care services from MCOs, patients have increasingly criticized the quality of care provided by these organizations.<sup>206</sup>

*Pegram* represents only one of a long line of catastrophes manifesting the seriousness of the injuries suffered by patients as a result of financial incentive arrangements. In *Lancaster v. Kaiser Foundation Health Plan*,<sup>207</sup> an eleven-year-old child who showed symptoms of "intense, localized headaches, vomiting, and blood-shot eyes," was denied necessary tests after visiting Kaiser's clinic for diagnosis. The physician prescribed pain medication, but did not refer the child to a neurologist.<sup>208</sup> Four and one half years after her initial visit, the child was found to have a brain tumor that had displaced forty percent of her brain.<sup>209</sup> The court indicated that the financial incentive program that paid physicians bonuses for avoiding excessive treatments and tests financially motivated this malpractice.<sup>210</sup> In order to reduce such negligent medical treatment and improve the quality of care, society must hold MCOs liable for inducing physicians to cut costs through financial incentive arrangements.

Proponents of the managed care system, however, emphasize the need to implement physician incentives to control the rising costs of healthcare despite quality concerns.<sup>211</sup> These proponents argue that physician incentives have successfully induced physicians to reduce costs by limiting care. They argue that cost containment, not quality, should be society's overriding concern.<sup>212</sup> According to these commentators, imposing tort liability on MCOs would undermine the purpose of managed care to decrease costs.<sup>213</sup> Society, however, should mistrust corporate entities that lack legal responsibility for the quality of care.<sup>214</sup>

The consequences of Congress immunizing MCOs from liability under ERISA, in light of the consequences if Congress allowed the cost of health care to escalate freely, fosters the need to strike an appropri-

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206. See Stuart Auerbach, *Managed Care Backlash: As Marketplace Changes, Consumers are Caught in the Middle*, WASH. POST., June 25, 1996, at Z12 (discussing study reporting that 53% of respondents felt that the healthcare system was getting worse while only 38% believed it was improving).

207. 958 F. Supp. 1137 (E.D. Va. 1997).

208. See *id.* at 1139.

209. See *id.* at 1140.

210. See *id.*

211. See Robert J. Herrington, Herdrich v. Pegram, *ERISA Fiduciary Liability and Physician Incentives to Deny Care*, 71 U. COLO. L. REV. 715, 755 (2000); Noah, *supra* note 8, at 1263-64.

212. See Marsh, *supra* note 27, at 1331.

213. See generally Battaglia, *supra* note 38.

214. See Havighurst, *supra* note 203, at 11.

ate balance to avoid them both.<sup>215</sup> Fiduciary tort liability strikes the best balance between cost containment and quality maintenance.<sup>216</sup> The threat of fiduciary liability will force MCOs to consider quality standards in the treatment of patients. At the same time, imposing a fiduciary standard of accountability will only increase costs if malpractice results. Thus, society can maintain MCOs' competitive structure without sacrificing patient well-being in the name of profit. MCOs will be mindful that too much focus on profit instead of care will undermine the actualization of profits, since liability costs money. Without liability to offset the cost-containment goals, the healthcare system would lack checks and balances to protect the vulnerable patient. Lower health costs will provide little benefit unless the system can simultaneously maintain a reasonable standard of quality.

It seems that Congress always intended quality to override concerns of cost-containment under ERISA. While some commentators argue that Congress gave no thought to the competing objectives of ERISA and the HMOA,<sup>217</sup> ERISA's legislative history indicates that Congress attempted to reconcile the two statutes' potentially conflicting purposes. In fact, the House Committee on Education and Labor acknowledged that effectuating the primary purpose of ERISA — to protect beneficiaries from the potential funding abuses of plan administrators—would result in "modest cost increases" to the health care system.<sup>218</sup> In other words, Congress recognized that it would be impossible to protect the interests of beneficiaries without cost. Yet, it seems that Congress supported those cost increases because of the importance of protecting beneficiaries under ERISA. Thus, Congress

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215. See *id.* at 10 ("Public policy has not yet hit upon an approach that will cause health plans and their subcontractors to concern themselves with quality in health care as much as they do currently, and controversially, about cost.").

216. See Roland, *supra* note 5, at 1524 (stating that "[n]egligence suits provide an important counterbalance to MCO's financial incentive schemes that could entice physicians to make self-serving, potentially detrimental, health-care decisions.").

217. See Marsh, *supra* note 27, at 1336 (stating that "[a]s forward-looking as ERISA was at the time it was written, it does not specifically address the unique problems raised by the managed care industry.").

218. See *id.* (citing HOUSE COMM. ON EDUCATION AND LABOR, EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1874, H.R. REP. NO. 93-533, at 1 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4639). The House Committee on Education and Labor, to which the ERISA bill was initially referred for consideration, stated:

The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans. The relative improvements required by this Act have been weighed against the additional burdens to be placed on the system. While modest cost increases are to be anticipated when the Act becomes effective, the adverse impact of these increases has been minimized.

*Id.*

would not favor cutting costs under the managed care system to the extent that the cuts would harm beneficiaries.

Today, the cost-cutting methods of the managed care system do, in fact, harm beneficiaries' interests. Therefore, courts must choose to protect beneficiaries' interests over saving marginal costs to effectuate Congress' intent. Congress made clear that it favored quality of care over marginal cost-containment. By acknowledging this potential cost increase, Congress indicated that it did not want cost concerns of the HMOA to overshadow ERISA's primary purpose to protect the quality of services provided to beneficiaries. Thus, the Court's decision in *Pegram* manifests misplaced concerns about the cost containment goals of managed care.

### **B. Allowing MCOs to Administer Financial Incentives to Their Physicians Will Lead to Adverse Selection of Patients**

Financial incentives enable MCOs to shift the obligation of controlling costs to physicians.<sup>219</sup> In light of this financial pressure to contain costs, physicians could choose to care only for patients who require inexpensive treatments. Physicians may also avoid treating those who consume the most healthcare services.<sup>220</sup> These people consist of the most vulnerable members of our society—the elderly, the chronically ill and the poor.<sup>221</sup> As such, financial incentives potentially endanger the availability of healthcare to all Americans, undermining the result of managed care's ancillary goal – to afford more Americans access to health care.<sup>222</sup> The healthy and employed may be the only ones to benefit from the privatization of the health care system.

Physicians who reject "high risk" patients merely because they may jeopardize a health care provider's ability to reach its profit goals engage in adverse selection. Adverse selection harms society – espe-

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219. See Schwartz, *supra* note 145, at 632.

220. See Roland, *supra* note 5, at 1524, 1525 (stating that "provider incentives designed to promote cost-effective care could become incentives to stop providing care to high-risk populations if the incentives are universally applied without essential modifications.").

221. See *id.* at 1524; see also Health Care Financing Administration, Fact Sheet (visited Nov. 9, 2000) <<http://www.hcfa.gov/facts/f9702a.htm>> (noting that "[i]n fiscal year 1996, HCFA (Health Care Financing Administration) spent an estimated \$359.4 billion to finance care services to elderly, disabled, and poor Americans in the Medicare and Medicaid programs.").

222. See H.R. Rep. No. 93-533 at 1 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4676-77 (quoting the House Committee on Ways and Means, to which the bill was referred to amend the Internal Revenue Code) ("In broad outline, the objective is to increase the number of individuals participating in employer-financed plans. . .").

cially in service industries where there is a disparity of knowledge between the provider and the recipient. This disparity forces the recipient to almost blindly rely on the decisions of the provider. The health care industry presents one such situation of trust between provider and patient. Patients must rely on physicians for medical care due to the patient's limited skill and knowledge of medical issues.

Managed care compounds the problem when it forces physicians to make mixed treatment and eligibility decisions. Managed care physicians may deny treatment for eligibility reasons, even though the patient relies on the physician's medical judgment to make what seems to be a treatment decision. The essential relationship of trust between provider and patient is harmed when patients rely on a physician who denies them treatment for eligibility reasons.<sup>223</sup> MCOs will attest that the patient's symptoms do not require treatment, when in reality they are claiming patient "ineligibility" under the plan. To make matters worse, because most employees get their health benefits through their employers, the patient will most likely have to sue in federal court under ERISA because his or her claim will "relate to" his or her employee benefit plan. Thus, insulating MCOs from liability under ERISA, courts have opened the door for MCOs to adversely select patients.

Some commentators contend that physicians should be able to refuse expensive treatments to patients who need them under a "cost defense" argument. Commentators have advocated asserting the cost defense so physicians can avoid the high personal cost of potential medical malpractice suits.<sup>224</sup> Yet, the cost defense represents an emerging abuse of MCOs' leverage to adversely select patients.<sup>225</sup> Essentially, the cost defense enables physicians to claim that limited resources render them financially unable to provide the care required.<sup>226</sup> In essence, where administrators force physicians to make both eligibility and treatment decisions, physicians assert the cost defense to rationalize denying treatment to at-risk patients.

The cost defense also enables physicians abuse their enhanced bargaining power because it dangerously encourages physicians to rede-

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223. See *infra* Section IV.C for discussion.

224. See generally John J. Howard, *Medical Malpractice Liability and Cost Containment: Law and Economics in Conflict*, 43 FOOD DRUG COSM. L.J. 309, 329 (1988)(arguing that "[t]he unfairness of such liability [for treatment decisions based on cost] could be mitigated by allowing physicians an explicit cost-based defense").

225. But cf. Noah, *supra* note 10, at 1251 (arguing that the "cost defense" seems ideally suited to application in the managed care context).

226. See *id.*

fine what constitutes "medically necessary" treatment.<sup>227</sup> Physicians have a duty to provide all "medically necessary" treatment to patients. However, physicians could simply redefine "medically necessary" in the face of financial restraints that compel the physicians to deny treatment. Physicians hide their true financial motivation to deny treatment in an effort to "escape the constant recognition that financial limits compel them to do less than their best."<sup>228</sup> Although these physicians claim that they denied treatment because the patient's condition did not make treatment "medically necessary," in reality they denied treatment because determining that the patient was eligible for care would increase the physician's cost of doing business.

### C. Allowing Financial Incentive Arrangements Threatens Physicians' Duty of Loyalty to Their Patients

Financial incentive schemes have made it easy for MCOs to shift the financial risk of health care to physicians.<sup>229</sup> When MCOs offer physicians financial incentives to control costs, however, they obligate physicians to make plan eligibility decisions that conflict with the physician's traditional obligation to act in the best interest of their patient.<sup>230</sup>

This conflict endangers the patients' rightful access to lifesaving medical interventions by motivating physicians to compromise the quality of care for an increase in profit.<sup>231</sup> In so doing, MCOs have perverted the core principles of the traditional practice of medicine by allowing physicians to take their own financial well being into consideration when making treatment decisions.

When Congress proposed to change the healthcare system to reduce costs and afford more people access to treatment, Congress did not intend to undermine a physician's ethical responsibility to her patients.<sup>232</sup> If it had, Congress would have taken upon itself to change the 2500-year-old Hippocratic ethic of physician loyalty to patients!<sup>233</sup>

227. See generally Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1654 (1992)(referring generally to medically necessary treatment).

228. Norman G. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573, 1574 (1984)(quoting H.J. AARON & W.B. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE* (1984)).

229. See Marsh *supra* note 27, at 1341.

230. *Id.* at 1324-25 (quoting Levinsky, *supra* note 229, at 1573)("[p]hysicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations.").

231. See Marsh, *supra* note 27, at 1324.

232. See Roland, *supra* note 5, at 1488, 1493 (stating that managed care took over much of the American health insurance and that ERISA contained "[n]o express Congressional intent to affect, or especially to protect health insurers.").

233. See COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS, CURRENT OPINIONS WITH ANNOTATIONS, at x (1996-1997)(stating that the Oath of Hip-

Obviously, Congress did not intend to do that. In reality, Congress exercised incredible foresight by passing ERISA, which acknowledged the climactic pervasiveness of employee benefit plans.<sup>234</sup> Congress recognized the need to protect beneficiaries' from the injurious efforts to reduce costs that eventually emanated from the managed care system.<sup>235</sup> Congress would not have stripped patients of their timeless fiduciary protection in light of their goal to protect beneficiaries.<sup>236</sup>

In the traditional fee-for-service system, society protected patients by imposing a fiduciary duty on the person or entity in control of the patients' welfare.<sup>237</sup> Thus, the fiduciary responsibility was traditionally placed on the physician who directly controlled patient care.<sup>238</sup> Traditional fee-for-service physicians had no conflicting financial interest because they were paid for each service they performed.<sup>239</sup> Hence, fee-for-service physicians complied with the physician standards of professional responsibility.

In today's era of managed care, however, physicians have a conflicting financial interest.<sup>240</sup> Physicians must concern themselves with limiting the costs of health care as a result of industry pressures to make a profit for the MCO.<sup>241</sup> As the physician's employer, MCOs dictate the terms by which the physician can provide care, terms that reflect MCOs' primary concern of financial gain.<sup>242</sup> Thus, physicians' hands are tied by the system that values profits over patients' lives.

The managed care system must reinstate the fiduciary protection afforded patients under the fee-for-service system. Accordingly, as MCOs procure more control over the provision of health care services to patients, MCOs must assume responsibility when negligent care results from financial incentives imposed on physicians. In the alternative, MCOs should devise incentive schemes that facilitate the

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pocrates "was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. . . . [and] has remained in Western civilization as an expression of ideal conduct for the physician.").

234. See discussion *supra* notes 29-35 and accompanying text.

235. See *Varity Corp. v. Howe*, 516 U.S. 489, 538 (1995)(Thomas, J., dissenting)(citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987))(discussing the "careful balance Congress struck in enacting ERISA").

236. See Roland, *supra* note 5, at 1499 (stating that ERISA provisions interpreted by courts have "stripped Americans of their historical legal protections against health insurance companies' negligence.").

237. See PERRITT, *supra* note 181, at 58-59.

238. See *id.*

239. See DEAN M. HARRIS, *HEALTHCARE LAW AND ETHICS: ISSUES FOR THE AGE OF MANAGED CARE* 267 (1999)(stating that under the fee-for-service medicine, the physician's financial interest was aligned with the patient's interest).

240. See *id.* at 267-68.

241. See KNIGHT, *supra* note 22, at 21 (stating that managed care "epitomizes short-sighted efforts to reduce health care costs with little regard to patients and physicians or the relationship between them.").

242. See *id.* at 23.



performance of the physician's professional responsibility to his or her patients. MCOs must limit compensation agreements that put physicians in conflict with their patients' best interests and in breach of their fiduciary duty.

It is important for MCOs to acknowledge the commitment a physician has to his or her patient, to which doctors swear when they take the Hippocratic Oath.<sup>243</sup> If the current system disables doctors from carrying out their fiduciary responsibility, then fiduciary liability must shift to the entity that has the control to carry out the essential fiduciary role. But in *Pegram*, the court closed off an avenue of liability toward the one entity that had the power to redeem the quality of care provided to patients under the system of managed care.

## V. CONCLUSION

Most Americans receive health care through employer-provided benefit plans, subjecting the lives of millions of employees and beneficiaries to the provisions of ERISA that insulate MCOs from liability. As MCOs gain more control over the provision of patient care, courts can no longer justify insulating from liability the very entities that have the power to taint physicians' decisions and control the fate of patients' lives. This Note ultimately emphasizes the need for Congress, in the absence of judicial leadership, to step in and amend ERISA to include an explicit cause of action against the MCOs that administer physician incentive plans.

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243. See *supra* note 234.